

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## DEPARTMENT OF PUBLIC HEALTH AND WELFARE

4734-63-017496  
STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. **318** Primary Registration District No. **1003** Registrar's No. **4734**

**FILED MAY 9 1963**

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Missouri</b> b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>St. Louis</b>		c. CITY OR TOWN <b>St. Louis</b>	
Length of stay in 1b <b>1 Month</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Homer G. Phillips</b>		d. STREET ADDRESS (If outside, give location) <b>4219 W. Finney</b>	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First <b>Carl</b> Middle Last <b>Cole</b>			4. DATE OF DEATH Month <b>4</b> Day <b>26</b> Year <b>63</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>5/11/11</b>	9. AGE (last birthday) <b>51</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Custodian</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>St. Louis Police Dept.</b>		11. BIRTHPLACE (City and state or country) <b>Meridian, Miss.</b>	
12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		13a. FATHER'S NAME <b>PETER COLE</b>			
13b. MOTHER'S MAIDEN NAME <b>ISABEL BURTON</b>		14. NAME OF HUSBAND OR WIFE <b>LUCILLE COLE</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		17. INFORMANT <b>St. Louis, Missouri</b> <b>Lucille Cole, 5060 Easton Avenue,</b>			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>Carcinoma of Lung</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <b>163x</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>Undet.</b>
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)
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20c. TIME OF INJURY Hour <b>6:59</b> a.m. p.m. <b>P.</b> Month, Day, Year <b>2-11-63</b>	20d. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20e. CITY, TOWN, OR LOCATION <b>St. Louis</b>	COUNTY <b>St. Clair</b>	STATE <b>Illinois</b>
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20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <b>St. Louis</b>	COUNTY <b>St. Clair</b>	STATE <b>Illinois</b>
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21. I attended the deceased from <b>2-11-63</b> to <b>4-26-63</b> and last saw him alive on <b>4-26-63</b> Death occurred at <b>6:59 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.	
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22a. SIGNATURE <b>F.O. Richard</b> (Degree or title)	22b. ADDRESS <b>2601 N. Whittier</b>	22c. DATE SIGNED <b>4-26-63</b>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>5/1/63</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Gardens of Memory</b>	23d. LOCATION (City, town, or county) (State) <b>Stokey Township, St. Clair, Illinois</b>
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24. FUNERAL DIRECTOR <b>Monroe Off</b>	25. DATE RECD. BY LOCAL REG. <b>APR 30 1963</b>	26. REGISTRAR'S SIGNATURE <b>Loan Smith, M.D.</b>
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USE BLACK INK  
OR  
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

VS 300  
Rev. 4/59

1

2 **2/1/63**

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4 **2**

5 **1**

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12 **77-0**

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**77**

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Marion C. Offner

Licensed Embalmer No. 5177

P. O. Address St. Louis, Ill.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.